NCLEX-RN$^{Q\&As}$

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QUESTION 1

A newborn is admitted to the newborn nursery with tremors, apnea periods, and poor sucking reflex. The nurse should suspect:

A. Central nervous system damage

B. Hypoglycemia

C. Hyperglycemia

D. These are normal newborn responses to extrauterine life

Correct Answer: B

(A) Central nervous system damage presents as seizures, decreased arousal, and absence of newborn reflexes. (B) In a diabetic mother, the infant is exposed to high serum glucose. The fetal pancreas produces large amounts of insulin, which causes hypoglycemia after birth. (C) Hypoglycemia is a common newborn problem. Increased insulin production causes hypoglycemia, not hyperglycemia. (D) These are not normal adaptive behaviors to extrauterine life.

QUESTION 2

When preparing insulin for IV administration, the nurse identifies which kind of insulin to use?

A. NPH

B. Human or pork

C. Regular

D. Long acting

Correct Answer: C

(A, B, D) Intermediate-acting and long-acting preparations contain materials that increase length of absorption time from the subcutaneous tissues but cause the preparation to be cloudy and unsuitable for IV use. Human insulin must be given SC. (C) Only regular insulin can be given IV.

QUESTION 3

A client takes warfarin (Coumadin) 15 mg po daily. To evaluate the medication\\'s effectiveness, the nurse should monitor the:

A. prothrombin time (PT)

B. partial thromboplastin time (PTT)

C. PTT-C

D. Fibrin split products

Correct Answer: A

(A) PT evaluates adequacy of extrinsic clotting pathway. Adequacy of warfarin therapy is monitored by PT. (B) PTT evaluates adequacy of intrinsic clotting pathway. Adequacy of heparin therapy is monitored by PTT. (C) There is no such laboratory test. (D) Fibrin split products indicate fibrinolysis. This is a screening test for disseminated intravascular coagulation. Heparin therapy may increase fibrin split products.

QUESTION 4

A 25-year-old outpatient presents with a diagnosis of compulsive personality disorder. His coworkers become annoyed with his rigid, perfectionistic manner and preoccupation with trivial details and schedules. A nursing intervention appropriate for this client would include:

A. Encouraging him to engage in recreational activities

B. Avoiding discussion of his annoying behavior

C. Encouraging the client to set a time schedule and deadlines for himself

D. Contracting with him for the amount of time he will spend on the compulsive behaviors

Correct Answer: D

(A) This answer is incorrect. The client will work hard at the activity instead of enjoying it. (B) This answer is incorrect. The nurse should allow the client to discuss these thoughts, within limits, not to avoid discussing them. (C) This answer is incorrect. The compulsive client tends to control time to excess. It should not be encouraged. (D) This answer is correct. A contract with the client regarding the amount of time that will be spent discussing the compulsive activities is appropriate. Time allotted should be gradually decreased.

QUESTION 5

The primary focus of nursing interventions for the child experiencing sickle cell crisis is aimed toward:

A. Maintaining an adequate level of hydration

B. Providing pain relief

C. Preventing infection

D. O2 therapy

Correct Answer: A

(A) Maintaining the hydration level is the focus for nursing intervention because dehydration enhances the sickling process. Both oral and parenteral fluids are used. (B) The pain is a result of the sickling process. Analgesics or narcotics will be used for symptom relief, but the underlying cause of the pain will be resolved with hydration. (C) Serious bacterial infections may result owing to splenic dysfunction. This is true at all times, not just during the acute period of a crisis. (D) O2 therapy is used for symptomatic relief of the hypoxia resulting from the sickling process. Hydration is the primary intervention to alleviate the dehydration that enhances the sickling process.

QUESTION 6

A 47-year-old client has been admitted to the general surgery unit for bowel obstruction. The doctor has ordered that an NG tube be inserted to aid in bowel de-compression. When preparing to insert a NG tube, the nurse measures from the:

A. Lower lip to the shoulder to the upper sternum

B. Tip of the nose to the lower lip to the umbilicus

C. End of the tube to the first measurement line on the tube

D. Tip of the nose to the ear lobe to the xiphoid process or midepigastric area

Correct Answer: D

(A) This measurement is _50 cm (48?9 cm). Fifty centimeters is considered the length necessary for the distal end of the tube to be in place in the stomach. This measurement is too short. (B) This measurement is _50 cm (47?8 cm). Fifty centimeters is considered the lengthnecessary for the distal end of the tube to be in place in the stomach. This measurement is too short. (C) This measurement gives an approximate indication of the length necessary for the distal end of the tube to be in place in the stomach, but it is not as accurate as actually measuring the client (nose-earxiphoid). (D) This is the correct measurement of 50 cm from the tip of the client\\'s nose to the tip of the earlobe to the xiphoid process (called the NEX [nose-ear-xiphoid] measurement). It is approximately equal to the distance necessary for the distal end of the tube to be located in the correct position in the stomach.

QUESTION 7

A 4-year-old child is being discharged from the hospital after being treated for severe croup. Which one of the following instructions should the nurse give to the child\\'s mother for the home treatment of croup?

A. Take him in the bathroom, turn on the hot water, and close the door.

B. Give him a dose of antihistamine.

C. Give large amounts of clear liquids if drooling occurs.

D. Place him near a cool mist vaporizer and encourage crying.

Correct Answer: A

(A) Initial home treatment of croup includes placing the child in an environment of high humidity to liquefy and mobilize secretions. (B) Antihistamines should be avoided because they can cause thickening of secretions. (C) Drooling is a characteristic sign of airway obstruction and the child should be taken directly to the emergency room. (D) Crying increases respiratory distress and hypoxia in the child with croup. The nurse should promote methods that will calm the child.

QUESTION 8

Three hours postoperatively, a 27-year-old client complains of right leg pain after knee reduction. The first action by the nurse will be to:

A. Assess vital signs

B. Elevate the extremity

C. Perform a lower extremity neurovascular check

D. Remind the client that he has a client-controlled analgesic pump, and reinstruct him on its use

Correct Answer: C

(A) Vital signs may be altered if there is acute pain or complications related to bleeding or swelling, but they should not be assessed before checking the affected extremity. (B) The extremity will be elevated if ordered by the doctor. (C) Assessment of the postoperative area is important to determine if bleeding, swelling, or decreased circulation is occurring. (D) Reinforcement of teaching on use of the client-controlled analgesic pump is important, but not the first action.

QUESTION 9

The day following his admission, the nurse sits down by a male client on the sofa in the dayroom. He was admitted for depression and thoughts of suicide. He looks at the nurse and says, "My life is so bad no one can do anything to help me." The most helpful initial response by the nurse would be:

A. "It concerns me that you feel so badly when you have so many positive things in your life."

B. "It will take a few weeks for you to feel better, so you need to be patient."

C. "You are telling me that you are feeling hopeless at this point?"

D. "Let\\'s play cards with some of the other clients to get your mind off your problems for now."

Correct Answer: C

(A) This response does not acknowledge the client\\'s feelings and may increase his feelings of guilt. (B) This response denotes false reassurance. (C) This response acknowledges the client\\'s feelings and invites a response. (D) This response changes the subject and does not allow the client to talk about his feelings.

QUESTION 10

A psychotic client who believes that he is God and rules all the universe is experiencing which type of delusion?

A. Somatic

B. Grandiose

C. Persecutory

D. Nihilistic

Correct Answer: B

(A) These delusions are related to the belief that an individual has an incurable illness. (B) These delusions are related to feelings of self-importance and uniqueness. (C) These delusions are related to feelings of being conspired against. (D) These delusions are related to denial of self-existence.

QUESTION 11

To appropriately monitor therapy and client progress, the nurse should be aware that increased myocardial work and O2 demand will occur with which of the following?

A. Positive inotropic therapy

B. Negative chronotropic therapy

C. Increase in balance of myocardial O2 supply and demand

D. Afterload reduction therapy

Correct Answer: A

(A) Inotropic therapy will increase contractility, which will increase myocardial O2 demand. (B) Decreased heart rate to the point of bradycardia will increase coronary artery filling time. This should be used cautiously because tachycardia may be a compensatory mechanism to increase cardiac output. (C) The goal in the care of the MI client with angina is to maintain a balance between myocardial O2 supply and demand. (D) Decrease in systemic vascular resistance by drug therapy, such as IV nitroglycerin or nitroprusside, or intra-aortic balloon pump therapy, would decrease myocardial work and O2 demand.

QUESTION 12

A new mother experiences strong uterine contractions while breast-feeding her baby. She excitedly rings for the nurse. When the nurse arrives the mother tells her, "Something is wrong. This is like my labor." Which reply by the nurse identifies the physiological response of the client?

A. "Your breasts are secreting a hormone that enters your bloodstream and causes your abdominal muscles to contract."

B. "Prolactin increases the blood supply to your uterus, and you are feeling the effects of this blood vessel engorgement."

C. "The same hormone that is released in response to the baby\\'s sucking, causing milk to flow, also causes the uterus to contract."

D. "There is probably a small blood clot or placental fragment in your uterus, and your uterus is contracting to expel it."

Correct Answer: C

(A) Mammary growth as well as milk production and maintenance in the breast occur in response to hormones produced primarily by the hypothalamus and the pituitary gland. (B) Prolactin stimulates the alveolar cells of the breast to produce milk. It is important in the initiation of breast-feeding. (C) Oxytocin, which is released by the posterior pituitary, stimulates the let-down reflex by contraction of the myoepithelial cells surrounding the alveoli. In addition, it causes contractions of the uterus and uterine involution. (D) Afterpains may occur with retained placental fragments. A boggy uterus and continued bleeding are other symptoms that occur in response to retained placental fragments.

QUESTION 13

A 6-year-old child returned to the surgical floor 20 hours ago after an appendectomy for a gangrenous appendix. His mother tells the nurse that he is becoming more restless and is anxious. Assessment findings indicate that the child has atelectasis. Appropriate nursing actions would include:

A. Allowing the child to remain in the position of comfort, preferably semi-or high-Fowler position

B. Administering analgesics as ordered

C. Having the child turn, cough, and deep breathe every 1

Correct Answer: C

(A) Allowing the client to remain in the position of comfort will not resolve the atelectasis. This position, if left unchanged, over time may actually increase the atelectasis. (B) Analgesics will not resolve the atelectasis and may contribute to it if proper nursing actions are not taken to help resolve the atelectasis. (C) Having the client turn, cough, and deep breathe every 1

QUESTION 14

The nurse is developing a plan of care for a client with an electrolyte imbalance and identifies a nursing diagnosis of decreased physical mobility. Which alteration is most the etiology?

A. Hypernatremia

B. Hypocalcemia

C. Hypokalemia

D. Hypomagnesemia

Correct Answer: C

(A) A deficit in sodium concentration results in muscular weakness and lethargy. (B) Muscle fatigue and hypotonia are caused by hypercalcemia. (C) Muscle weakness and fatigue are classic signs of hypokalemia. (D) Hypermagnesemia can cause muscle weakness, paralysis, and coma.

QUESTION 15

A 40-year-old client is admitted to the hospital for tests to diagnose cancer. Since his admission, he has become dependent and demanding to the nursing staff. The nurse identifies this behavior as which defense mechanism?

A. Denial

B. Displacement

C. Regression

D. Projection

Correct Answer: C

(A) Denial is the disowning of consciously intolerable thoughts. (B) Displacement is the referring of a feeling or emotion from one person, object, or idea to another. (C) Regression is returning to an earlier stage of development. (D) Projection is attributing one\\'s own thoughts, feelings, or impulses to another person.

Questions